

Next Generation ACO Model



*Model Overview
Presentation*

March 24, 2015

Agenda

- **Model Overview**
 - Principles, Scope, and General Approach
- Financial Model
 - Benchmark
 - Risk Arrangements
 - Payment Mechanisms
- ACO Entities
 - Next Generation Providers/Suppliers, Preferred Providers, and Affiliates
 - Program Overlap
- Beneficiary Engagement
 - Alignment
 - Voluntary Alignment
 - Benefit Enhancements
- Program Reporting
 - Quality
 - Monitoring and Compliance
 - Data Sharing and Reports
- Evaluation
- Learning System

Next Generation ACO Model

- Authorized under Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act) that established the Center for Medicare and Medicaid Innovation (CMMI) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care.
- A new opportunity in accountable care:
 - More predictable financial targets;
 - Greater opportunities to coordinate care;
 - High quality standards consistent with other Medicare programs and models.
- The Model seeks to test how strong financial incentives for ACOs can improve health outcomes and reduce growth in expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

Model Principles

- Protect Medicare FFS beneficiaries' freedom of choice;
- Create a financial model with long-term sustainability;
- Use a prospectively-set benchmark that:
 - Rewards quality;
 - Rewards both attainment of and improvement in efficiency; and
 - Ultimately transitions away from updating benchmarks based on ACO's recent expenditures;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care;
- Allow beneficiaries a choice to remain aligned to the ACO;
 - Mitigates fluctuations in aligned beneficiary populations
 - Respects beneficiary preferences;
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.

Model Scope

- 15 to 20 ACOs
- Representation from a variety of provider organization types and geographic regions.
- Minimum aligned beneficiaries: 10,000 (7,500 for rural ACOs).
- Two opportunities to apply:
 - First application due June 1, 2015 for January 1, 2016 start date
 - Second application due June 1, 2016 for January 1, 2017 start date.

Duration of Agreement

- First cycle ACOs:
 - *Three* initial 12-month performance years.
 - First performance year: January 1, 2016 – December 31, 2016.
- Second cycle ACOs
 - *Two* initial 12-month performance years.
 - First performance year: January 1, 2017 – December 31, 2017.
- Following initial performance years, all ACOs have potential for *two* 12-month extensions (calendar years 2019 and 2020).

Financial Model

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Financial Goals and Opportunities

Goals:

- Increased ACO financial risk;
- Long-term fiscal sustainability;
- Benchmark predictability and stability.

ACO Opportunities:

- 1) Greater financial risk coupled with a greater portion of savings;
- 2) Flexible payment options that support ACO investments in care improvement infrastructure to provide high quality care to patients.

Prospective Benchmark (2016-2018)

The Benchmark will be prospectively set prior to the performance year using the following four steps:

Baseline

Determine ACO's baseline using one-year of historical baseline expenditures.

Trend

Trend the baseline forward using a regional projected trend.

Risk
Adjustment

The full HCC risk score will be used and allowed to grow by 3% between the baseline and the given performance year.

Discount

Apply discount derived from quality and efficiency adjustments.

Trend (2016-2018)

The baseline will be trended forward using a regional projected trend:

- National projected trend similar to that currently used in Medicare Advantage (MA).
- Regional prices applied to the national trend.
- Under limited circumstances, CMS may adjust the trend in response to payment changes with substantial expected impact (negative or positive) on ACO expenditures.

Risk Adjustment (2016-2018)

- The Next Generation ACO benchmark is cross-sectional:
 - Alignment algorithm applied separately to baseline year and performance year;
 - Populations in these two time periods may be different.
- Prospective CMS Hierarchical Condition Category (HCC) risk scores will be applied to both baseline and performance year populations.
- ACO's full HCC risk score will be allowed to grow with a 3% cap (performance year compared to the baseline). Decrease in HCC risk score will also be capped at 3%.

Discount (2016-2018)

- Once the baseline has been calculated, trended, and risk-adjusted, CMS will apply a discount.
- Summing the following components creates each ACO's discount:
 - Quality:
 - Range: **2.0% to 3.0%**
 - Formula: $[2.0 + (1 - \text{quality score})]\%$
 - Regional Efficiency:
 - Range: **-1% to 1%**
 - Compares the ACO's risk-adjusted historical per capita baseline to a risk-adjusted regional FFS per capita baseline.
 - National Efficiency:
 - Range: **-0.5% to 0.5%**
 - Compares the risk-adjusted regional FFS baseline to risk-adjusted national FFS per capita spending.
- Total discount range: **0.5% to 4.5%**

Alternative Benchmark Methodology (2019-2020)

- Principles for alternative benchmark methodology :
 - Eliminate or further de-emphasize the role of recent ACO cost experience when updating the baseline;
 - Take into account public comments received in response to the Shared Savings Program Notice of Public Rulemaking (NPRM) on alternative benchmark approaches;
 - Shift to valuing attainment more heavily than year-over-year improvement;
 - Consider the use of a normative trend;
 - Continue to refine risk adjustment for beneficiary characteristics that balances changes in disease burden against more complete coding;
 - Consider adjustments reflecting geographic differences in utilization or price changes.
- CMS intends to provide additional detail by the end of 2017.

Risk Arrangements

Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Parts A and B Shared Risk <ul style="list-style-type: none">• 80% sharing rate (PY1-3, 2016-2018)• 85% sharing rate (PY4-5, 2019-2020)• 15% savings/losses cap• Discount	100% Risk for Parts A and B <ul style="list-style-type: none">• 15% savings/losses cap• Discount

- Benchmarks calculated the same way for both arrangements.
- Different sharing rates affect ACO risk.
- For both arrangements, individual beneficiary expenditures capped at the 99th percentile of expenditures to moderate outlier effects.

Payment Mechanisms

Payment Mechanism 1: Normal FFS	Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payment	Payment Mechanism 3: Population-Based Payments (PBP)	Payment Mechanism 4: Capitation (2017)
Medicare payment through usual FFS process.	Medicare payment through usual FFS process plus additional PBPM payment to ACO.	Medicare payment redistributed through reduced FFS and PBPM payment to ACO.	Medicare payment through capitation; ACO responsible for paying ACO Provider/Supplier and Capitation Affiliate claims

- Goals of payment mechanisms:
 - Offer ACOs the opportunity for stable and predictable cash flow; and
 - Facilitate investment in infrastructure and care coordination.
- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures.

Infrastructure Payments

- All claims paid through normal FFS reimbursement.
- The ACO chooses an additional per-beneficiary per-month (PBPM) payment unrelated to claims.
- Maximum payment rate: \$6 PBPM
- All infrastructure payments will be recouped in full from the ACO during reconciliation regardless of savings or losses.
- Sufficiently large financial guarantee required to assure repayments to CMS.

Population Based Payments (PBP)

- ACO determines a percentage reduction to the base FFS payments of its ACO Providers/Suppliers.
- ACO may opt to apply a different percentage reduction to different subsets of its ACO Providers/Suppliers.
- ACO Providers/Suppliers participating in PBP must agree in writing to the percentage reduction.
- CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments.

Capitation (available in 2017)

- CMS will estimate total annual expenditures for Next Generation Beneficiaries and pay that projected amount to the ACO in a PBPM payment.
- Some money withheld to cover anticipated care by non-ACO providers and suppliers.
- ACO responsible for paying claims for its Providers/Suppliers and Capitation Affiliates.
- Claims process:
 - All providers and suppliers submit claims to CMS as normal
 - CMS sends ACOs claims information for those services
 - ACO responsible for making payments.
- CMS will continue to pay normal FFS claims for care furnished to Next Generation Beneficiaries by providers and suppliers not covered by a Next Generation capitation agreement.

Financial Reconciliation

- Savings or losses determined by comparing total Parts A and B spending for aligned beneficiaries to the benchmark.
 - Individual expenditures capped at the 99th percentile.
- Risk arrangement determines ACO's share of savings or losses.
- Annual savings payment or losses recoupment occurs following a year-end financial reconciliation.
- Additional accounting for monthly payments that occurred during the performance year through PBP, infrastructure payments, or capitation.
 - May result in monies owed from CMS to the ACO, or vice versa.

Financial Guarantees

- ACOs required to have in place a financial guarantee sufficient to cover potential losses.
- ACOs participating in infrastructure payments required to have a larger financial guarantee.
- ACOs required to comply with all applicable state laws and regulations regarding provider-based risk-bearing entities.

ACO Entities

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Eligible Providers/Suppliers

- Next Generation ACOs may be formed by Medicare-enrolled providers and/or suppliers structured as:
 - Physicians or other practitioners in group practice arrangements
 - Networks of individual practices of physicians or other practitioners
 - Hospitals employing physicians or other practitioners
 - Partnerships or joint venture arrangements between hospitals and physicians or other practitioners
 - Federally Qualified Health Centers (FQHCs)
 - Rural Health Clinics (RHCs)
 - Critical Access Hospitals (CAHs)
- Any other Medicare-enrolled providers/suppliers may participate in an ACO formed by one or more of the entities listed above.

Next Generation Preferred Providers

- Goal: Contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO:
 - ACO-selected set of partners to contribute to ACO goals;
 - May offer an ACO's benefit enhancements to aligned beneficiaries;
 - Services delivered to Next Generation Beneficiaries count toward the coordinated care reward calculation (direct payments made to beneficiaries by CMS);
 - Preferred Providers will NOT be associated with beneficiary alignment or used for quality reporting by the ACO;
 - Preferred Providers may also be Affiliates in order to participate in the capitation payment mechanism or the SNF 3-Day Rule waiver.

Next Generation Affiliates

- Two types of ACO partner entities associated with specific Next Generation design elements:
 - Capitation Affiliates
 - SNF Affiliates
- Goal: extend and advance ACO cost and quality goals.
- Affiliate care counts toward the coordinated care reward calculation.
- Preferred Providers may also be Affiliates.

Types of Next Generation Entities and Associated Functions¹

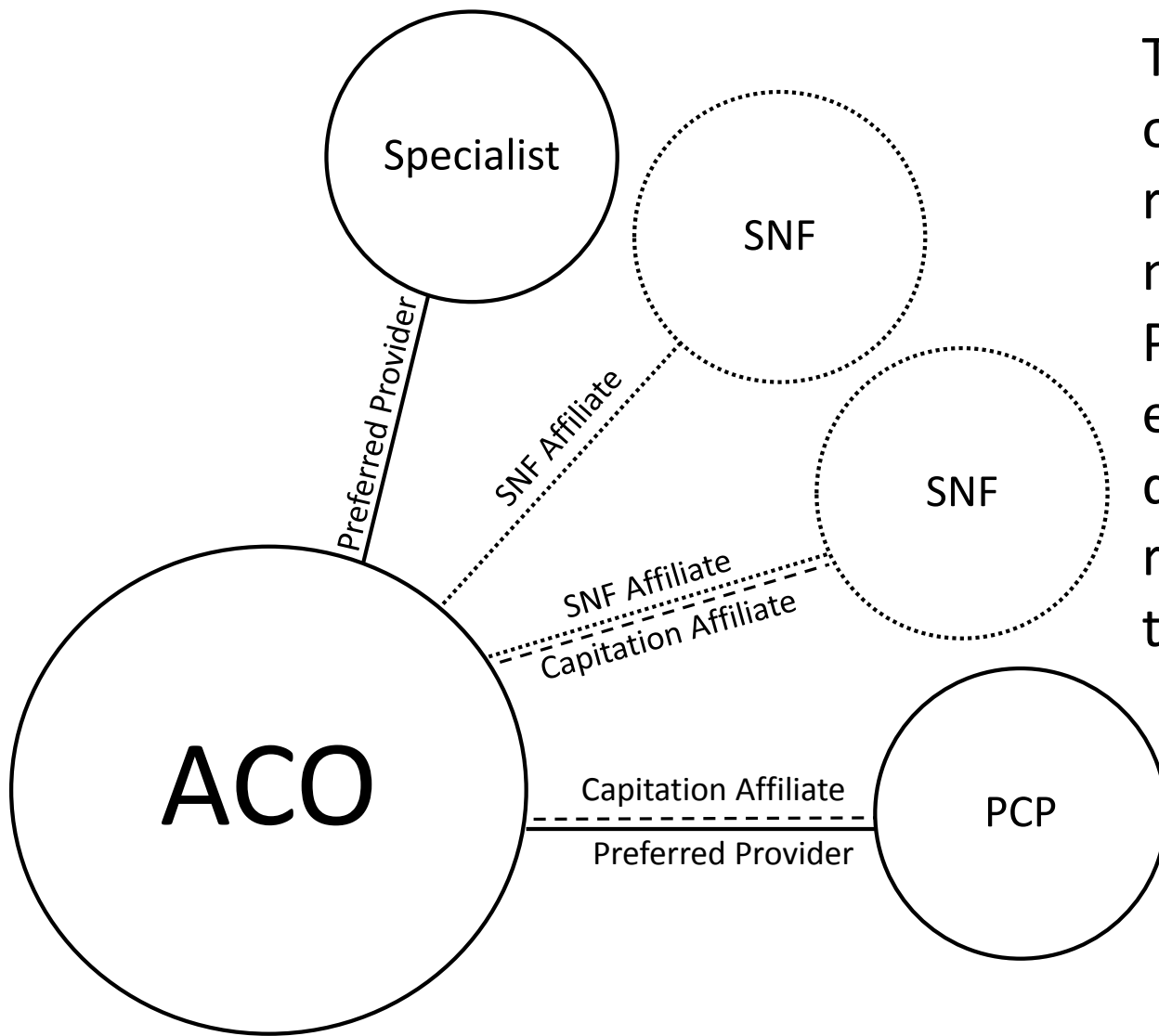
	Alignment	Quality Reporting Through ACO	Population-Based Payments	Capitation	Coordinated Care Reward	3-Day SNF Rule ³	Telehealth	Post-Discharge Home Visit
Provider/Supplier ²	●	●	●	●	●	●	●	●
Preferred Provider					●	●	●	●
SNF Affiliate					●	●		
Capitation Affiliate				●	●			

¹ This table is a simplified depiction of key design elements with respect to provider and supplier roles. It does not necessarily imply that this list of capabilities is exhaustive with regards to possible ACO relationships and activities.

² Providers/Suppliers may NOT also be any of the other three entity types. However, Preferred Providers, Capitation Affiliates, and SNF Affiliates are not mutually exclusive with respect to each other. For instance, a Preferred Provider may also be a Capitation Affiliate but not a Provider/Supplier.

³ There are two distinct roles involved in the 3-Day SNF Rule benefit enhancement: (1) admitting practitioners; and (2) SNFs. Admitting practitioners must either be Next Generation Providers/Suppliers or Preferred Providers. SNFs may be Next Generation Providers/Suppliers or SNF Affiliates. More information on the benefit enhancement may be found in Section VI.C.2. of the RFA.

Examples of ACO Relationships



This is a sample of some of the many possible relationships an ACO may have with non-Provider/Supplier entities. Each line depicts one type of relationship between the entity and the ACO.

Program Overlap

- **With other Medicare models and programs:**
 - Participation in other demonstrations or models generally *allowed*;
 - Next Generation ACOs *NOT allowed* to simultaneously participate in other Medicare shared savings initiatives (e.g., Shared Savings Program, Pioneer ACO Model)
 - Next Generation Provider/Supplier TINs *may not* overlap with Shared Savings Program TINs.
 - Preferred Provider and Affiliate TINs *may* overlap with Shared Savings Program TINs.
- **Within the Model:**
 - Primary care providers may be Providers/Suppliers in only one Next Generation ACO.
 - Specialists may be Providers/Suppliers in more than one Next Generation ACO.
 - Preferred Providers and Affiliates are not required to be exclusive to any one Next Generation ACO.

Beneficiary Engagement

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Beneficiary Engagement Overview

- Encourage greater care coordination and closer care relationships between the ACO and beneficiaries:
 - Supporting meaningful discussions and considerations about care through the voluntary alignment process.
 - Enhancing services beneficiaries can receive from ACOs.
 - Offering a coordinated care reward directly from CMS for beneficiaries seeking care from Next Generation Providers/Suppliers, Preferred Providers, and Affiliates

Beneficiary Alignment

- Two-stage alignment methodology to prospectively align beneficiaries
 - No change from Pioneer Model methodology;
 - Based on plurality of evaluation and management (E&M) services.
- Stage 1: Assess percentage of each beneficiary's outpatient E&M services delivered by Next Generation Providers/Suppliers in select primary care specialties. Beneficiaries with such ACO services comprising a plurality of their total care will be aligned to the ACO for the subsequent year.
- Stage 2: For beneficiaries with less than 10 percent of their E&M services delivered by Next Generation ACO primary care providers, alignment may be based on E&M services provided by practitioners with certain non-primary care specialties.

Voluntary Alignment

- Augments claims-based alignment by allowing beneficiaries a decision in their alignment to an ACO.
 - Available to currently- or previously-aligned beneficiaries.
 - During each PY, beneficiaries will have the opportunity to voluntarily align for the subsequent PY.
- ACOs may select the mode(s) of beneficiary confirmation.
- Direct provider-beneficiary communication about voluntary alignment allowed.
- Additional resources for beneficiaries:
 - 1-800-MEDICARE;
 - Regional offices;
 - State Health Insurance Assistance Program counselors.
- Voluntary alignment decisions from other ACO programs/models in 2015 will be retained for ACOs that transition into the Next Generation Model for PY1.

Potential Refinements to Voluntary Alignment

- In later years of the Model, CMS may:
 - Make alignment accessible to a broader group of Medicare beneficiaries, regardless of current or previous alignment;
 - Include affirmation of a general care relationship between beneficiaries and ACOs, instead of between beneficiaries and specific providers; and/or
 - Allow beneficiaries to *opt out* of alignment to a particular ACO in addition to *opting into* ACO alignment.

Benefit Enhancements

- Medicare payment rule waivers designed to improve care coordination and cost saving capabilities:
 - Telehealth expansion
 - Post-discharge home visits
 - 3-Day SNF Rule waiver
- ACO may decide which, if any, to implement.
- For each, ACOs must submit an implementation plan describing how the ACO will utilize, monitor, and report on the benefit enhancement.

Telehealth Expansion

- Elimination of geographic (rural) component of originating site requirements.
- Beneficiaries may receive certain telehealth services from place of residence.
- Telehealth services (CPT and HCPCS codes) unchanged.

Post-Discharge Home Visits

- A licensed clinician under the *general* – instead of direct – supervision of a Next Generation Provider/Supplier or Preferred Provider may bill for “incident to” services at an aligned beneficiary’s home.
- Such services may be furnished not more than one time in the first 10 days following discharge from an inpatient facility (hospital, CAH, SNF, IRF) and not more than one time in the subsequent 20 days.

SNF 3-Day Rule Waiver

- Eliminate the requirement of a 3-day inpatient stay prior to SNF admission.
- Similar to Pioneer Model
 - Available to aligned beneficiaries admitted by Next Generation Providers/Suppliers or Preferred Providers to eligible and CMS-approved SNF Affiliates.
 - Clinical criteria for admission, e.g., beneficiary must be medically stable with confirmed diagnosis of skilled nursing/rehab need.

Beneficiary Coordinated Care Reward

- All Next Generation Beneficiary automatically eligible.
- CMS will notify beneficiaries of their eligibility for a reward and refer them to lists of the ACO's Provider/Suppliers, Preferred Providers, and Affiliates.
- Reward earned if at least a specified percentage of patient encounters are with Next Generation Providers/Suppliers, Preferred Providers, and Affiliates.
- Payment made directly to beneficiaries from CMS.
- Projected values:
 - Reward amount: \$50/year (\$25 available semi-annually).
 - Reward threshold: 50% of patient encounters with ACO entities.
 - Values may change due to actuarial analysis

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Quality

- The Model will follow Shared Savings Program quality domains, measures, benchmarking methodology, sampling, and scoring.
 - Exception: the measure set will not include the electronic health record (EHR) measure.
- Pay-for-reporting in PY1;
- Pay-for-performance PY2 and later.
 - In PY1, 100% will be used as the quality score when calculating the discount prior to the start of the year.
 - In PY2, the score from the quality data reported for PY1 will be used in calculating the quality component of the discount.
 - In PY3 and later, the score from the quality data reported from 2 years prior will be used in calculating the quality component of the discount but ACOs will have the opportunity to use the score from 1 year prior if it is higher.

Monitoring and Compliance

- Plan designed to protect beneficiaries and address potential program integrity risks.
- New risks require additional safeguards.
- ACOs required to have a compliance officer and develop a compliance plan to be approved by CMS.
- Noncompliance with the terms of the participation agreement will result in corrective actions based on the type of issue, severity, and the ACO's compliance record.

Data Sharing

- CMS will share Medicare data to support care coordination and quality improvement efforts.
- ACOs must enter into a Data Use Agreement with CMS prior to receiving any data.
- ACOs not required to notify beneficiaries of data sharing opt-out option.
 - ACOs will notify beneficiaries of data sharing and respond to inquiring beneficiaries that they may opt out via 1-800-Medicare;
 - Model will honor previous data sharing opt-out decisions by beneficiaries, but these decisions may be reversed through 1-800-Medicare.

Reports

- CMS will provide Next Generation ACOs with data and reports on a regular basis.
- Support ACO analysis of ongoing performance and strategy.
- Reports may include, but are not limited to:
 - Baseline and Benchmark Reports;
 - Quarterly and Annual Utilization;
 - Monthly Expenditures; and
 - Beneficiary Alignment.

Evaluation and Learning

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Evaluation

- ACOs must cooperate with independent evaluation of the Model.
- Assess the impact of the Model on the goals of better health, better health care, and lower costs.
- Evaluation may include:
 - Participation in surveys;
 - Interviews;
 - Site visits; and
 - Other activities determined necessary by CMS.
- Evaluation seeks to understand, among other areas:
 - Behaviors of providers and beneficiaries;
 - Impacts of increased financial risk;
 - Effects of payment mechanisms and benefit enhancements;
 - Impact on beneficiary engagement and experience.

Learning and Diffusion

- Accelerating ACO progress through a “learning system.”
- CMS will provide opportunities to learn about and share experiences.
- Learning system will use various group learning approaches to help ACOs:
 - Share experiences;
 - Track progress; and
 - Rapidly adopt new methods for improving quality, efficiency, and population health.
- Next Generation ACOs will actively participate in the learning system:
 - Attending periodic conference calls and meetings;
 - Actively sharing tools and ideas through an online collaboration site.

Letter of Intent/Application Information for January 1, 2016 Start

- LOI accessible via Model website:
<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>
 - LOI deadline: 11:59 p.m. EDT, May 1, 2015.
- Application accessible via Model website:
<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>
 - Application deadline: 11:59 p.m. EDT, June 1, 2015.

Questions?

Next Generation ACO Model Webpage:

<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

E-mail: NextGenerationACOModel@cms.hhs.gov